

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Jackson
Civil Dist. # 3
OR
Village _____
OR
City _____ (No. _____, St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

Registration District No. 44403

File No. 324

Primary Registration District No. _____

Registered No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Stell Bonn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)
6 DATE OF BIRTH Feb-3-1921
(Month) (Day) (Year)
7 AGE _____ If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Tenn

10 NAME OF FATHER Rayton Cassette

11 BIRTHPLACE OF FATHER [State or country] Tenn

12 MAIDEN NAME OF MOTHER Mattie Blase

13 BIRTHPLACE OF MOTHER [State or country] Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
[Informant] Rayton Cassette
[Address] Haydenburg

15 Filed Feb-4-1921 M. H. Dycus
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb-3-1921
[Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from _____ 191____ to _____ 191____, that I last saw him alive on Feb-3-1921 and that death occurred, on the date stated above, at 3 P M
The CAUSE OF DEATH* was as follows

Stell Bonn

Contributory [SECONDARY] Knot in Cord

Signed F. D. Cornwell M. D.
Feb-4-1921 Address Gambelton

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, if not at place of death?
_____ former or _____ usual residence

19 PLACE OF BURIAL OR REMOVAL Camp Grant DATE OF BURIAL Feb-4-1921

20 UNDERTAKER Don Witt ADDRESS Waltham